Corrected

No. 80-1952

IN THE

Supreme Court of the United States

October Term, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONERS

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TABLE OF CONTENTS

PAGE

A. No respondent, intervenor or class representative was injured or threatened with injury by the private physician and nursing home transfers to different levels of care or by the Utilization Review Committee transfers to higher levels of care on review 2

B. State action is not involved in private physician and nursing home transfers of Medicaid patients to different levels of nursing home care or in Utilization Review Committee transfers of these patients to higher levels of care 8

Conclusion 20

TABLE OF AUTHORITIES

PAGE

Cases:

Allee v. Medrano, 416 U.S. 802 (1974) 6

Burton v. Wilmington Parking Authority, 365 U.S. 715 (1961) 8, 18

Cape Cod Nursing Council v. Rambling Rose Rest Home, 667 F.2d 238 (1st Cir. 1981) 19

Flagg Brothers, Inc. v. Brooks, 436 U.S. 149 (1978) 10, 18

Flast v. Cohen, 392 U.S. 83 (1968) 2

Gladstone Realtors v. Village of Bellwood, 441 U.S. 91 (1979) 3

Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974) ..... *passim*

Moose Lodge No. 107 v. Irvis, 407 U.S. 163 (1972) 11

Musso v. Suriano, 586 F.2d 59 (7th Cir. 1978), *cert. den.*, 440 U.S. 971 (1979) 18

O'Shea v. Littleton, 414 U.S. 488 (1974) 4

Polk County v. Dodson, —— U.S. ——, 50 U.S.L.W. 4077 (Dec. 14, 1981) 11

RAM v. Blum, 432 N.Y.S.2d 892 (App. Div. First Dep't 1980) 19

Robinson v. Wood, 464 F. Supp. 983 (E.D. Ill. 1979) 17

Valley Forge Christian College v. Americans United for Separation of Church and State, Inc., —— U.S. ——, 50 U.S.L.W. 4103 (Jan. 12, 1982) 2, 3

PAGE

Federal Statutes:

42 U.S.C.:
§ 1396a 12, 18
§ 1396b 12
§ 1396d 12

State Statutes:

New York Public Health Law:
§ 2801-d 17

New York State Constitution:
Article 17, §§ 1, 3 19

Federal Regulations:

42 C.F.R.:
§ 405.1121 17
§ 431.213 16
§ 431.220 ..... 16, 17
§ 442.306 12
§ 442.311 17
§ 456.260 12
§ 456.270 12
§ 456.280 13
§ 456.305-.306 11
§ 456.320 12
§ 456.331-.338 11
§ 456.360 12
§ 456.380 13
§ 456.405-.407 11
§ 456.431-.438 11
§ 456.606 14

PAGE

State Regulations:

10 New York Code Rules and Regulations:
§ 414.4 17
§ 415.1 ..... 12, 13
§ 416.1 14
§ 416.9 ..... 11, 12, 14
§ 420.1 ..... 12, 13
§ 421.3 14
§ 421.13 ..... 11, 12, 13, 14
§ 704.1 13
§ 730.2 12
§ 741.13 13
18 NYCRR § 360.29 18

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REPLY BRIEF FOR PETITIONERS

A. No respondent, intervenor or class representative was injured or threatened with injury by the private physician and nursing home transfers to different levels of care or by the Utilization Review Committee transfers to higher levels of care on review.

Respondents' assertion that the transfers on review present a justiciable controversy and, therefore, satisfy Article III jurisdiction, misses the point.* The requirement of standing "focuses on the party seeking to get his complaint before a federal court and not on the issues he wishes to have adjudicated." *Flast* v. *Cohen*, 392 U.S. 83, 99 (1968). The parties and class representatives before the district court in this case were the named respondents and intervenors, and they complained only about URC transfers to lower levels of care. Their claims were finally determined by the October 17, 1979 Partial Final Judgment (A. 227). See main brief, pp. 8-13, 16-17, 26-28.** Although respondents and intervenors may have wanted to litigate one or more of the numerous statutory and constitutional questions that may be involved in the private physician and nursing home transfers to different levels of care or in the URC transfers to higher levels of care on review, none had standing to do so because none complained that he was transferred or threatened with transfer in this manner. See *Valley Forge Christian College* v. *Americans United for Separation of Church and State, Inc.*, —— U.S. ——, 50 U.S.L.W. 4103, 4105 (Jan. 12, 1982) and main brief, pp. 25-28.

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* In this brief, the term "transfers" includes discharges from nursing home care unless otherwise specified in the text. See petitioners' brief ("main brief"), p. 7 & n.*.

** Respondents (brief, pp. 2, 7 n.6, 15-16, 18-19) concede that URC transfers to lower levels of care are not on review.

Respondents (brief, pp. 2-6, 15-16) attempt to avoid this result by claiming that they, the intervenors or other class members, have been subject to continuing threats with respect to the transfers in issue, although they did not complain about them below. These alleged threats are either non-existent or speculative and, therefore, do not present the prospect of "distinct and palpable injury" Article III requires. See *Valley Forge Christian College* v. *Americans United for Separation of Church and State, Inc., supra*, at 4106; *Gladstone Realtors* v. *Village of Bellwood*, 441 U.S. 91, 99 (1979); main brief, p. 25.

Respondents first argue that although their own URC transfers to lower levels of care and those of the intervenors were enjoined by the October 17, 1979 Partial Final Judgment (A. 227) (as well as by earlier orders, brief, pp. 1-2), they remained subject to continuing threats of transfers by their nursing homes based on the same URC decisions (brief, pp. 3, 15-16, 19-20).* These alleged threats do not withstand scrutiny.

Respondents concede that the proprietors and administrators of all nursing homes in New York (in addition to

* Respondents (brief, pp. 18-20) offer an apparent variant of this argument when they claim the continuing threats of transfers, to which they were subject by reason of the injunctive orders in this case, extended to all adverse URC transfers, including URC transfers to higher levels of care. This argument falls of its own weight. Since the injunctive orders on which respondents rely in this context restrained only URC decisions transferring Medicaid patients to lower levels of care (discussion above and at p. 4), respondents' and intervenors' nursing homes could not threaten them with transfers to higher levels of care based on these same URC decisions. Indeed, nursing homes never had occasion to threaten patients with transfers to higher levels of care, which could not be accomplished by enjoined URCs, since nursing home transfers to higher levels of care were both enjoined by the December 13, 1979 Partial Final Judgment (A. 241-43) which was affirmed by the opinion and judgment on review (A. 245).

the petitioners) were enjoined from implementing URC transfers to lower levels of care (without certain procedural rights) by temporary restraining orders (*e.g.*, A. 45-46) and by the January 5, 1978 preliminary injunction (A. 100-102) issued at the outset of this case (brief, pp. 2, 19 n.15).* As a result, nursing homes could not permit URC transfers of Medicaid patients to lower levels of care and could not adopt these URC decisions as their own initiatives as respondents' argument would require. If it is assumed that nursing homes were free to adopt the URC transfer decisions as their own, neither the record nor the papers before the Court suggest that they did so or threatened to do so. Indeed, respondent Yaretsky remained in the American Nursing Home for one and one-half years (without court order) after the URC decision transferring him to a lower level of care was affirmed by the New York State Department of Social Services. Petition, p. 4 n.*.** At the time the petition was filed, respondent Cuevas had stayed in American for five years after the URC decision transferring him to a lower level of care was affirmed by the Department. *Ibid.*

If respondents' argument is intended to show that nursing homes, like the respondents' and intervenors' own physicians, were free to transfer them for reasons outside the orders cited above, *i.e.*, for reasons other than the URC decisions transferring them to lower levels of care, they are

* The preliminary injunction was later affirmed by the Court of Appeals (A. 122).

** According to the Petition (*ibid.*), Yaretsky was transferred from American to Bellevue Hospital in mid-1977. His nursing home to hospital transfer is not among the patient transfers considered in this case.

correct. Both physicians and nursing homes always were, and continue to be (until the opinion and judgment on review), free to transfer their patients, based on their own judgments and subject only to applicable federal and state laws and professional ethics. The possibility that the respondents or intervenors might be subject to other transfers, in addition to the URC transfers they placed before the district court, does not afford them standing with respect to the other transfers. As shown (pp. 2-3, 5-7) and in the main brief, pp. 26-28, respondents and intervenors did not, and do not now, show that they were subject to or threatened with other transfers, and their rights, with respect to the URC transfers with which they were in fact involved, were finally determined by the October 17, 1979 Partial Final Judgment (A. 227).*

Respondents (brief, p. 20) next argue that if the physician, nursing home and URC transfers in issue cannot be attributed to respondents and intervenors themselves, they can be attributed to the class they represent. The argument fails immediately because a class member's standing does not exceed that of his class representative, and respondents and intervenors were the only class representatives before the court. *O'Shea* v. *Littleton*, 414 U.S. 488, 494 (1974);

* Respondents' (brief, pp. 18, 19 n.16) two passing references to the Gray Panthers in their standing argument add nothing. Respondents have yet to address petitioners' point that the Gray Panthers were excluded from the litigation of the transfers in issue by the terms of the Pretrial Order (A. 150 ¶A; 151 ¶B) and the December 13, 1979 Partial Final Judgment (A. 241-42 ¶2). See main brief, p. 29. Respondents' reliance on *United States* v. *SCRAP*, 412 U.S. 669, 688 (1973), is inapposite since petitioners put the Gray Panthers' standing in issue when it was first alleged (A. 35 ¶ *Third*; A. 37 ¶ *Fourteenth*), and there was no need to pursue the matter with respect to the transfers in issue since the organization had already been excluded by the Pretrial Order.

main brief, pp. 8, 15, 29. As stated in *Allee* v. *Medrano*, 416 U.S. 802, 828-29 (1974) (BURGER, C.J. concurring): "[A] person cannot predicate standing on injury which he does not share. Standing cannot be acquired through the back door of a class."

The several references in respondents' brief (pp. 2, 6, 20) to individuals other than the respondents and intervenors also fail in their purpose of identifying a class representative or member who has standing to contest the transfers in issue. Respondents first refer to "several cases of facility threats outside of the . . . (UR) process" (brief, p. 2) which were moot before the transfers in issue were first raised in the October 17, 1979 Partial Final Judgment (A. 227). *Ibid.*

Respondents (brief, pp. 6, 20) next refer to three letters, outside the record, from New York State Department of Health employees to nursing home employees.* Two letters identify Medicaid patients who were to be transferred from their nursing homes by their private physicians and advise the nursing home employees that the patients are to receive notice and opportunity for hearings (Ruid letters). The third letter does not identify any patient but says the same thing in response to a particular inquiry (Maddaloni letter). Since the letters show, in terms, that they were written after the transfers in issue were adjudicated by the December 13, 1979 Partial Final Judgment (A. 241) and that they were intended to assist in implementing that judgment, they cannot be said to identify any class member who had standing to contest the transfers before the dis-

* The letters are attached to respondents' brief in opposition to the petition.

trict court. Of further interest, since the letters are devoted to procedures required by the judgment, they give no indication of whether the two patients identified wanted pre-transfer notice and hearing or would have preferred to do without them.

Respondents (brief, p. 5) refer last to ten Medicaid patients, identified during discovery, who had fair hearings on their URC transfers to higher levels of care during a brief period prior to December, 1978, when State policy required such hearings. See main brief, p. 13 n.**; A. 181 ¶G(IV)(58), (59). As appears, these individuals cannot be identified as class members with standing since they, like the individuals cited in respondents' first two references, had the relief the class sought.

Respondents' (brief, pp. 16, 20-21) final standing argument fares no better than the others. Petitioners did not "stipulate" to the inclusion of the transfers in issue in the Pretrial Order (respondents' brief, pp. 4, 5, 16, 20-21). Respondents merely alleged those claims in the order which were, in turn, subject to all appropriate defenses. Nor did petitioners "stipulate" to the expanded definition of the class in the Pretrial Order (respondents' brief, pp. 4, 5, 16, 20-21). However, the point need not be resolved. As shown, pp. 5-6, and in the main brief, pp. 25 n.*, 29, the standing of a class is determined by the standing of the parties or class representatives. If, as in this case, standing of the parties and representatives is jurisdictionally deficient under Article III, standing of the class is also deficient, and its jurisdictional deficiency cannot be waived by agreement of counsel.

B. State action is not involved in private physician and nursing home transfers of Medicaid patients to different levels of nursing home care or in Utilization Review Committee transfers of these patients to higher levels of care.

Respondents' state action argument first characterizes the private physician, nursing home and URC transfers on review as "involuntary out-of-facility transfers by nursing facilities" (brief, p. 22 n.21) and then argues that state action is present in them, as well as in *"all"* like transfers (*ibid.*, emphasis original), on the theory that the nursing facilities are either required or encouraged to make the transfers by specific federal and state laws or by their interdependent relationship with the state (brief, pp. 17-18, 21-28). *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974), and *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961), are the principal cases cited in support of the alternative rationales (brief, pp. 23-25, 28-32).*

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* Respondents include transfers that result from the following decisions in the class of *"all* involuntary out-of-facility transfers" (brief, p. 22 n.21, emphasis original) and assert that they are before the Court for review (brief, p. 22 & n.20): any "medical decision of a facility staff physician, the patient's attending physician, the facility medical director, or (in some transfers to a higher level of care) a URC determination" and any "purely non-medical decision of a facility operator that the patient is troublesome, antisocial, disturbed, or just plain undesirable."

Medical decisions transferring patients "out-of-facility" but within the same level of care, included in the preceding list, are not before the Court for review. The December 13, 1979 Partial Final Judgment (A. 242-43), as well as the opinion below (A. 247, 248-50), exclude these "lateral" medical transfers, and the Court of Appeals state action analysis depends on the exclusion. A. 247, 248-50 and main brief, pp. 21, 23-24, 32-34, 35-37. *Contrast* respondents' brief, pp. 22 n.20 & n.21.

The "purely non-medical decisions" included in the list were not addressed below except insofar as they involved an assessment

(footnote continued on next page)

The argument is specious in all material respects. The constraints of state action analysis do not permit respondents to attribute the private physician and URC decisions they describe to nursing homes any more than they permit respondents to attribute all medical (or non-medical) decisions by nursing homes to the state. The same constraints preclude respondents from relying on a patient's disagreement with these decisions as the touchstone for state action since the decisions must be identified with the state before the question of deprivation of rights is addressed.

The medical decisions of private and "attending" physicians to change their patients' levels of care and those of URCs to move their patients to higher levels of care cannot become "nursing facility transfers" in respondents' lexicon simply because a nursing home permits these private initiatives to be implemented.* Even if the nursing home were the state itself, its conduct in this regard would be no more than acquiescence in private action and would not provide any basis for attributing the physician and URC decisions

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of a patient's medical needs. *Contra* December 13, 1979 Partial Final Judgment (A. 242-43) with respondents' brief, p. 22 n.20). To the extent that they may be read into the judgment, they are subject to the same Article III deficiencies as respondents' claims against the physician, nursing home and URC transfers based on medical decisions. See subpoint A and main brief, Point I. Further, they are not decisions involving state action and are not the appropriate subject of "fair hearings."

* Respondents do not challenge the Court of Appeals findings (A. 126, 249-50) that the physicians and URCs in question are private parties and that their decisions about the level of care their Medicaid patients should receive are free of state action when made (A. 126, 249-50). Their assertion (brief, p. 19 n.14) that the nursing home, not the physician or the URC, actually discharges patients only evidences the fact that the home is implementing the prescribed change in care, not that it is initiating the change or is responsible for the patient's dissatisfaction with the decision. *Contra* respondents' brief, pp. 19 n.15, 20.

to the home. *Jackson, supra,* at 357-58; *Flagg Brothers, Inc.* v. *Brooks,* 436 U.S. 149, 164-66 (1978). Further, since the transfers are private initiatives and are identified with nursing homes only by reason of the latter's acquiescence, they must be excluded from the class of nursing facility transfers relied on in respondents' principal *Jackson* argument, *i.e.,* those affirmatively commanded encouraged by federal and state laws. *Contrast* respondents' brief, pp. 17, 23-25.

Although a nursing home's own medical decisions to change its patients' levels of care (made by a "facility staff physician" or a "facility medical director," respondents' brief, p. 22) as well as its non-medical transfer decisions (made by a "facility operator," *ibid.*), are nursing facility transfers, as respondents use that term, they do not involve state action. As the Court made clear in *Jackson, supra,* at 351, 357, a private party's exercise of its own initiative in making choices allowed by state (or federal) law is not conduct which can be attributed to the state itself absent a showing that the state has ordered, or at least acted affirmatively, with respect to the choice in question.

The array of federal and state laws respondents cite to show that the *Jackson* standard applies in their favor because the state either affirmatively commands the nursing home to make the transfers in question (brief, pp. 17, 23-25) or reviews and approves or rejects them (brief, pp. 17-18, 26-27) does not serve that purpose. Rather, as shown below, these laws, when relevant at all, demonstrate that the state (and federal government) leave nursing homes (as well as physicians and URCs) free to assess their patients' medical needs and to decide for themselves whether the patients

should be transferred to different levels of nursing home care or discharged from that kind of care. As a result, *Jackson*, as well as *Polk County v. Dodson*, ___ U.S. ___, 50 U.S.L.W. 4977 (Dec. 14, 1981) and *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 172 (1972), require a finding that no state action is present in the transfers on review. *Contra* respondents' brief, pp. 17 n.24, 25.

The first federal and state law citations which respondents provide to support their argument that the state affirmatively commands nursing home to make the transfers in issue largely describe admissions rather than continued stays,* transfers, or discharges, and speak in broad terms, *i.e.*, SNFs and ICFs** are to admit only those patients for

* Respondents' use of the term "continued stay" (as well as some of their references) opposes their claim (brief, pp. 7 n.6, 9 n.12, 17) that they are relying on federal and state laws which are outside the utilization review. Continued stay review is required by, and is part of utilization review ("UR"), 42 C.F.R. §§ 456.131, 456.328, 456.333, 456.432; 10 New York Code Rules and Regulations ("NYCRR") §§ 416.9(b), 421.13(b). If respondents are attempting to distinguish UR from utilization review committees ("URC's), possibly because of the Court of Appeals finding that URC decisions are private acts (A. 249-50), their distinction is false. URC's and their decisions are part of UR. See 42 C.F.R. §§ 456.305, 456.306, 456.307, 456.307; 10 NYCRR §§ 416.9, 421.13.

** Respondents refer to the nursing homes that offer a less intensive level of nursing care by their federal term, ICFs, rather than their New York term, HRFs. Their usage is followed here. Their federal and state laws discussion (brief, pp. 7-15) also includes numerous references to the federal Medical Assistance Manual and to state administrative memoranda. The state memoranda (albeit not the federal manual) are said to have the force and effect of law (brief, p. 9 n.10 & n.11). Neither the federal manual nor the state memoranda have such an effect. They merely interpret controlling laws and regulations and are disregarded in this discussion. Petitioners' attorneys have in fact reviewed all the interpretative material respondents cite (except for HHS Manual § 6-9-20, quoted in respondents' brief, p. 11, as § 00-90-20) and have found that material consistent with their discussion of the federal and state laws involved.

whom they can provide care (42 C.F.R. § 442.306; 10 NYCRR §§ 415.1(b), 420.1(d), 730.2(b) [parallel reference]*), and patients are to be evaluated for admission in terms of their need for the care SNFs and ICFs provide. 42 C.F.R. §§ 456.270(a), 456.320(a). The requirement that a patient who is, or wants to be, Medicaid-funded have his need for SNF or HRF services certified by a UR physician before payment is authorized and every sixty days thereafter is cited. 42 U.S.C. § 1396b(g)1(A),(B); 42 C.F.R. §§ 456.260(a), (b), 456.360(a), (b).** Emphasis is placed on the LongTerm Care Placement Form ("DMS-1") (and related Numerical Standards Master Sheet ["DMS-9"]) which New York requires for all admissions (brief, p. 8).† The forms are intended to assist and inform medical decision-makers about the intensity of nursing home care a patient needs, if any, not to make the decision about care for them. Thus, the various weights assigned to

* Regulations in the 700 series of Title 10, NYCRR, generally restate regulations in the 400 series, and duplicative references to the 700 series in respondents' brief are disregarded hereafter. Citation to the 400 series is to be preferred because that series defines the minimum standards upon which certificates of operation depend. To the extent the 700 series is not duplicative of the 400 series, it is viewed as unenforceable by the administering agency.

** An individual must meet two essential conditions to obtain Medicaid. He must be eligible in terms of income and resources (42 U.S.C. §§ 1396a[1], 1396a[a][10]), and he must need medically necessary services. 42 U.S.C. §§ 1396a[1], 1396d[4][A], [c]. The physician certification requirement which respondents identify implements the medically necessary requirement of the program. It is the only law cited in respondents' discussion and here that applies exclusively to Medicaid patients in New York. All other laws, including UR review, apply to both private and publicly assisted patients. 10 NYCRR §§ 416.9, 421.13. See Joint Statement of Facts ¶ G(H)(16) (A. 170) erroneously stating the contrary with respect to UR. *Contrast* Brief *Amicus Curiae*, Point III.

† The forms are reproduced in Appendix C-1 to Title 10 (Vol. C), NYCRR.

medical conditions and related circumstances do not impose a "cut-off score" on the decision maker or on the patient's access to care. *Contrast* respondents' brief, p. 8 n.8. As appears from the controlling regulations, a physician's certification of a patient's need for care always overrides a "low" score on the forms. 10 NYCRR §§ 415.1(a)(2), 420.1(b)(2).

When respondents turn to transfers and discharges specifically (brief, pp. 8-9), they again cite broadly framed regulations which permit SNF's and HCF's to admit and "retain" only those patients for whom they can provide care (10 NYCRR §§ 415.1[b], 420.1[a][1][11],421.13[d]), as well as several which require that patients, who are dangerous, have communicable diseases, etc., to be transferred to other settings. 10 NYCRR §§ 415.1(i), 420.1(i)(2)-(4).* The discharge planning regulations respondents cite (brief, pp. 8-9), and upon which their argument that federal and state laws command the discharges in question would appear to depend, do not so command. The federal regulations require SNF's and HCF's to have "plans for discharge" without more. 42 C.F.R. §§ 456.280(b)(6), 456.380(b)(6). The state regulations (for SNF's) cited say that the "patient care and discharge plan" must be provided by the patient's "personal, alternate or staff physician," working with others, and "summarize," *inter alia*, "the patient's potential for return to the community, for transfer to another more appropriate setting or for achieving or maintaining the best obtainable level of function in the nursing

Two non-duplicative regulations in the 700 series of Title 10, NYCRR (see p. 12 n.) are cited (brief, p. 9). They are intended to assure that HCF patients have access to more intensive nursing and medical services if they need them (§ 741.13[a][3]) and that patients are transferred among licensed facilities (§ 766.1[b][2]).

home." 10 NYCRR § 416.1(k)(2)(ii). The HRF regulation, 10 NYCRR § 421.3(a), (b), is identical in all material respects. The state UR regulations cited (brief, p. 9) simply require SNF and HRFs to have orderly discharge procedures and to "complete" the DMS-1 and DM-9 forms discussed earlier. 10 NYCRR §§ 416.9(d), 421.13(d). The memoranda cited at the conclusion of the respondents' discussion (brief, p. 10) do not require nursing homes to rely on the forms for admissions purposes, they simply permit them to do so, and no federal or state law directs nursing homes to admit particular patients, or directs patients to particular nursing homes. *Contrast* respondents' brief, pp. 11-12, 24-25, 27, 30.

The second federal and state law citations which respondents provide (brief, pp. 10, 24) to support their argument that the state commands nursing homes to make the transfers in issue are completely inapposite. States are, as respondents claim, required to undertake annual on-site inspections of SNFs (PMR reviews) and ICFs (IPR reviews) to determine the "quality of care and services being provided . . . and the condition of the recipients" (42 C.F.R. § 456.606), and New York does so (A. 135-36).* It is possible, as respondents also claim, for an inappropriately placed patient to be discovered during an inspection and for the state investigating team, to recommend the patient's transfer or discharge to the nursing

* New York is currently "on waivers" from this regulation based on its conduct of an HHS approved demonstration project. However, it continues to make periodic quality assurance inspections. Those inspections examine care and services provided to private and publicly assisted nursing home patients as they have in the past.

home, or in an extraordinary circumstance, for state health officials to direct the transfer. No such state-initiated transfers are presented by the record in this case, and in the latter illustration, the Fourteenth Amendment inquiry would focus on whether the patient transferred by state health officials had been deprived of a protected liberty or property interest, a question not now before the Court. Similarly, if state officials decide to fine or decertify a nursing home for an abusive practice, for example, discharging, on medical grounds, patients who are appropriate for the level of care it provides and/or retaining others who are not, no problematic question of state action is presented. However, contrary to respondents' view (brief, pp. 17, 25), the laws which empower the state to proceed in this manner cannot be read as requiring the nursing home to engage in the very conduct, *e.g.*, transferring patients who are appropriately placed, that they are intended to punish.

Respondents' (brief, pp. 17-18, 26-27) attempt to show that the state acts affirmatively with respect to the transfers in issue (even if it does not command them) by reviewing and approving or rejecting physician, URC and nursing home decisions in particular cases fails entirely. The state certification that nursing home care is medically necessary is issued at, or before, admission and periodically thereafter while the patient remains in long-term care. See p. 12 & n.**. *Contrast* respondents' brief, pp. 12-13, 26. There is no certification requirement for transfers or discharges from care, and no certification is issued. The Department of Health does require that DMS-1 forms be com-

pleted and filed (respondents' brief, pp. 12, 26 n.25), including those issued during continued stay reviews where no transfer or discharge has occurred.* However, it does not review them, or the change in care, on the merits.** As established in the main brief, Point II, the adjustment in Medicaid benefits made by the Department of Social Services following a transfer is not an assessment of the merits of the change in level of care decision, it is an acceptance of that decision intact. *Contrast* respondents' brief, pp. 26-27. Indeed, the Department has no obligation to address the merits of these decisions except at the fair hearings mandated by the October 17, 1979 Partial Final Judgment in this case (A. 227) and by the opinion and judgment on review (A. 245) which affirmed the December 13, 1979 Partial Judgment (A. 241).†

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* The Department has used the forms principally as a data base for statistically oriented studies about nursing home needs within the state.

** New York City Medicaid authorities reviewed URC transfers to lower levels of care at one time. This practice was discontinued in 1977 when the state took over the City's long-term care responsibilities. Main brief, p. 5 n.**.

† Respondents argue (brief, Point III) incorrectly that the Department's obligation to hear and determine the validity and appropriateness of the transfers in issue can be found in federal and state laws. Fair hearings in the Medicaid program are limited procedural vehicles which permit claimants to be heard on state agency decisions adverse to them that are within the power of the agency to redress. None of the regulations cited (brief, p. 5) oppose this principle, and thus none afford fair hearing rights on the non-agency transfer decisions in issue. *See, e.g.*, 42 C.F.R. § 431.220(a)(1) (agency did not decide transfers; no basis for a denial of a "claim for services" presented); *id.*, § 431.220(a)(2) (accuracy of agency's conforming adjustment of benefits after transfer, unchallenged; no basis for a claim of erroneous agency action presented). Reference (brief, p. 5) to 42 C.F.R. § 431.213(f) is not in point. The regulation exempts changes in levels of care prescribed by physicians from advance notice to recipients. It does not afford recipients a right to a fair hearing on the merits of the physician's decision. Its evident purpose is to

(footnote continued on next page)

Respondents (brief, pp. 11-12, 27) conclude their argument under *Jackson* by contending that the transfers on review oppose the state's alleged obligation to provide nursing home care for all Medicaid patients and its further alleged obligation to secure the free choice of those patients to remain in nursing homes once they have been submitted. The alleged obligations do not exist, and the physician, nursing home and URC transfers in question conform with the federal and state laws on which respondents must rely. The Medicaid program does not require states to provide SNF or ICF services or to guarantee all recipients a nursing home placement. It provides funding for certain services, including nursing home care offered by qualified providers, for individuals who have demonstrated both financial eligibility and a medical need for the service they seek. See p. 12 & n.2 and main brief, p. 4n.**. The question of medical need is determined in the first instance by a medical professional, and, if answered affirmatively by him, considered

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enable the recipient to challenge the benefits he receives from the agency as erroneous under § 431.220(a)(2) if they do not reflect the change in care.

The patients' bill of rights, 42 C.R.F. §§ 405.1121(k)(4), 442.311(c); 10 NYCRR § 414.4(a)(4), repeatedly cited by respondents (brief, pp. 11-12, 23 n.23, 34 n.34) and the source of the "purely non-medical" transfers they contend are in issue (p. 8 n.* of this brief), does not provide fair hearing rights for recipients. It does provide for patient claims against their nursing homes, including the claim that a patient not be discharged except for "medical reasons, or for his welfare or that of other patients, or for nonpayment of his stay . . . ." 42 C.F.R. § 405.1121(k). *Roberson* v. *Wood*, 464 F. Supp. 983 (E.D. Ill. 1979). See also New York Public Health Law § 2801-d. This focus for patient/nursing home disputes is appropriate and should obtain with respect to the transfers in issue. Both parties are before the court, and relief which is both complete and enforceable can be awarded. The URC, the entity with which respondents and intervenors in fact have a dispute, is not a party to fair hearings, and the form of relief available there, adjustment in benefits, does not permit the respondents and intervenors to reverse the URC determination that they did not need SNF or ICF care.

by state Medicaid program personnel for certification purposes. See p. 12 & n.2. The free choice provisions, 42 U.S.C. § 1396a(a)(23); 18 NYCRR § 360.29, prohibit the state from restricting the individual's access to providers who offer services that are consistent with his demonstrated medical need. They do not permit the individual to determine his own need or require nursing home providers to admit or retain individuals, like respondents and intervenors, who do not have a medical need for the services the provider offers. As noted p. 16 n.†, if the individual wants to dispute a nursing home's judgment, or that of a physician or URC, his remedy is against those individuals and entities, and not in a proceeding against the state to obtain reimbursement for services that a provider has found that the individual does not need and that the state cannot force the provider to offer him.

Respondents' argument (brief, pp. 28-32) that proprietary and voluntary nursing homes in New York stand in a sufficient interdependant relationship with the state to find state action present under *Burton* v. *Wilmington Parking Authority*, *supra*, is foreclosed by the analysis of that case presented in *Jackson*. As the Court there found (419 U.S. at 357-58), privately-owned enterprises, operating on their own land and responsible for providing their own services, although extensively regulated, do not come under *Burton*. Proprietary and voluntary nursing homes in New York meet all the indicia *Jackson* cited in distinguishing *Burton*.

In addition, they do not perform any function traditionally associated with sovereignty, *Flagg Brothers Inc.* v. *Brooks*, *supra*, at 171, see *Musso* v. *Suriano*, 586 F.2d 59

(7th Cir. 1978), *cert. den.*, 440 U.S. 971 (1979) and cases cited in the main brief, p. 36, and are not "company towns." *Cape Cod Nursing Council* v. *Rambling Rose Rest Home*, 667 F.2d 238 (1st Cir. 1981). *Contrast* respondents' brief, p. 30 & n.31. Neither the Medicaid program nor state laws imposes any special duty on the state with respect to nursing home services for indigents which is executed by nursing homes. See pp. 17-18. *Contrast* respondents' brief, p. 30 & n.31.* The fact they receive federal and state monies does not identify them with the state for Fourteenth Amendment purposes. Main brief, p. 36 and cases there cited.**

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* The New York Constitution, Art. 17, §§ 1, 3, merely authorizes the legislature to provide funds for the care of the needy in its discretion. *RAM* v. *Blum*, 432 N.Y.S.2d 892 (App. Div. First Dep't 1980). It does not mandate that any particular kind of care be provided much less long-term nursing home care.

** Proprietary and voluntary (not-for-profit) nursing homes are not guaranteed a profit under New York's reimbursement methodology. *Contrast* respondents' brief, p. 29.

CONCLUSION

For the foregoing reasons and those set forth in the Brief for Petitioners, the Judgment below should be vacated as entered without jurisdiction, or, alternatively, it should be reversed, and physician and nursing home transfers of Medicaid patients to different levels of care and discharges from care as well as Utilization Review Committee transfers of Medicaid patients to higher levels of care should be declared free of state action under the Fourteenth Amendment.

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(This brief has been re-printed to conform with the text provided to printer by the attorneys for petitioners on March 19, 1982 and provided by said attorneys to John E. Kirklin, lead attorney for respondents, on that date.)

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